MOOD DISORDERS IN THE ELDERLY

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OUTLINE OF PRESENTATION

- Introduction
- Epidemiology (Incidence and Prevalence)
- Etiology
- Diagnostic Work Up
- Clinical Presentation
- Diagnosis and Differential Diagnosis
- Suicide
- Treatment

STATISTICS

- 1980 - 10% > 65 = 25 Million
- 1900 - 3% > 65 = 3 Million
- 1992 - 12% > 65 = 30 Million
- Fastest Growing Cohort in our Society: > 85
- > 100 (Willard Scott's Group)= 32,000
- 2020 - More > 65 than < 18
- 2080 - MORE THAN ONE MILLION > 100

MOOD DISORDERS ARE:

Common in the Elderly

- Significant cause of Morbidity and Mortality
- Tend to be more persistent than in younger patients
- “Failure to Thrive” syndrome
- Linked to increased Physical Pain in Patients with Medical Problems (especially Arthritis & Cancer)
- Depressed Elderly Increased Risk of Mortality from Medical Illness as Compared with Age Matched Controls

DEPRESSION IN THE ELDERLY IS A MAJOR PUBLIC HEALTH PROBLEM

Many go undiagnosed

- Diagnosis is challenging in context of Multiple Physical Problems
- Feeling in both Patients and Caregivers/Health Personnel that Depression is a normal consequence of all the Physical, Social and Economic Problems of the Elderly

THREE QUESTIONS TO ADDRESS

- How does Depression in Late Life differ from Depression earlier in life? What are the sources of heterogeneity within Late Life Depression?
- How prevalent is Depression in the Elderly and What are its Risk Factors?
- What constitutes Safe and Effective Treatment for Late Life Depression? What are the Indications and Contraindications for Specific Treatments?

DEPRESSION

"Depression is a Syndrome which includes a Constellation of Physiological, Affective and Cognitive Manifestations."

SIGNS & SYMPTOMS ACCORDING TO THE DSM IV ARE:

- Changes in Appetite
- Disturbed Sleep
- Motor Agitation or Retardation
- Fatigue and Loss of Energy
- Depressed or Irritable Mood
- Loss of Interest or Pleasure in Usual Activities
- Feelings of Worthlessness, Self-Reproach, Excessive Guilt
- Suicidal Thinking or Attempts
- Poor Concentration

IN THE ELDERLY

- Clinicians and patients attribute (incorrectly) depressive symptoms to the aging process
- Expectations of lower level of functioning in the post-retirement years
- Symptoms may differ, the elderly may readily report somatic symptoms i.e. chronic pains, gastrointestinal distress, etc. rather than depressed mood
- More attention paid to the physical problems by clinicians - Depression is overlooked

DEPRESSION FREQUENTLY COEXISTS WITH MULTIPLE CHRONIC DISEASES & DISABILITIES

- Cancer, cardiovascular disease, neurological disorders, various metabolic disturbances, arthritis, and sensory loss. All these can directly contribute to the cause of depression and can complicate treatment.
- Advancing age is accompanied by loss of important social support systems due to death of spouse, siblings, friends, retirement, or relocation.

SOURCES OF HETEROGENEITY

- Biologically there is usually a slowing of the :
  - Organ Systems
  - Decrease in Immunologic Responsiveness
  - Change in Body Composition
- Leading to major implications for risk of illness, diagnosis, and treatment.
- Antidepressants levels can be disproportionately high making the aged particularly vulnerable to adverse side effects.

LATE ONSET DEPRESSION IS ASSOCIATED WITH:

- A lower frequency of the family history of depression
- A higher frequency of cognitive impairment, cerebral atrophy, recurrences and medical comorbidity, and mortality

EPIDEMIOLOGY

- According to the Epidemiologic Catchment Area Study (EPA), *Depressive Symptoms* occur in approximately 15% of community residents over 65 years of age.
- *Prevalence of Depression* in the elderly living in the community is estimated at 2 to 3%. The rate of Depression in Primary Care Clinics is 15%, in Nursing Homes 25 to 30%.
- New episodes of Depression in a 1-year period in Nursing Homes is 13%, and another 18% Develop New Depressive Symptoms.

RISK FACTORS FOR DEPRESSION

- Social and demographic
  - Women
  - Unmarried/Widowed
  - Stressful Life Events
  - Lack of Supportive Social Network
- Physical Conditions
  - Stroke
  - Cancer
  - Dementia-Pseudodementia (Dementia Syndrome of Depression)

RISK FACTORS FOR DEPRESSION (con't)

- Depression in medically ill patients enhances vulnerability of the immune system
- Some medications commonly used can cause depression
  - Beta Blockers e.g. Inderal
  - Anti Glaucoma medication e.g. Betaxolol & Timolol
  - Pain Medication e.g. Narcotics

DIAGNOSIS

- No specific diagnostic lab test can be recommended at this time. Therefore, an Attentive and Focused Clinical Interview remains the mainstay for the evaluation and diagnosis of depression.
- Depression assessment scales for clinical use
  - Geriatric Depression Scale

SUICIDE IN THE ELDERLY

- Over 6,000 elderly persons die each year of Suicide
- Elderly persons represent only 12% of the US population but account for 20% of Suicides.

SUICIDE IN THE ELDERLY

- Many older individuals who completed their Suicide had Diagnosable Mental Illness(Carlson, 1984)
- Depression is the most common mental illness for those who have Attempted Suicide (Lyness, Conwell, and Nelson, 1992)
- Biologic factors related to Suicide include reduced levels of Serotonin (Asberg et al., 1976; Prung, 1982)

FACTORS ASSOCIATED WITH RISK FOR SUICIDE IN THE ELDERLY INCLUDE:

- HIGH SOCIOECONOMIC STATUS
- PAST SUICIDE ATTEMPTS
- MORE PERSISTENT INDEX EPISODES OF DEPRESSION

(Maahan, Salzman, Sattin, 1991)

SUICIDE IN THE ELDERLY:

- More than 80% of elderly individuals who committed suicide had visited their primary care physician within a month of their death and 29% had done so within 24 hours. (AARP, 1993)

TREATMENT OF DEPRESSION IN THE ELDERLY

- **GOALS OF TREATMENT**
  - Decreasing Symptoms of Depression
  - Reducing Risk of Relapse and Recurrence
  - Increasing Quality of Life
  - Improving Medical Health Status
  - Decreasing Health Care Costs and Mortality

TREATMENT (con't)

- Two major categories of treatment are:
  - Biological (Pharmacotherapy & ECT)
  - Psychosocial Therapy

TREATMENT (con't)

- ANTIDEPRESSANTS - TYPICALS

  TRICYCLICS

  - Most commonly used and studied
  - Desipramine, Nortriptyline
  - Avoid Amitriptyline and Imipramine

DIFFERENTIAL SIDE EFFECTS OF TRICYCLIC ANTIDEPRESSANTS IN THE ELDERLY

Drug class	Sedation	Orthostasis	Anticholinegic Effects
Tertiary Amines			
(Imipramine, Amitriptytine, Doxepin	Strong	Strong	Strong
Secondary Amines			
Desipramine	Activating	Moderate	Weaker
Nortriptyine	Moderate	Weaker	Moderate
Protriptyine	Activating	Moderate	Moderate

TREATMENT OF DEPRESSION (con't)

Antidepressants (con't)

- Selective Serotonergic Reuptake Inhibitors (SSRI's)
  - Fluoxetine (Prozac)
  - Sertraline (Zoloft)
  - Paroxetine (Paxil)
  - Fluvoxamine (Luvox)
  - Citalopram (Celexa)
  - Escitalopram (Lexapro)

SSRI THERAPY OF DEPRESSION

- As effective as TCAs:
  - Doxepin vs Paroxetine or Fluoxetine
  - Amitriptyline vs Paroxetine, Fluoxetine, or Sertraline
- Minimal Anticholinergic Effects
- No Orthostasis
- Agents with long half-lives may accumulate in elderly and prolong side effects

SSRI'S AND THE ELDERLY:

- "A major advantage of these agents (Sertraline {Zoloft} and Fluoxetine {Prozac}) over other antidepressants is that they may be *less lethal when taken in overdose*; this is of particular concern in the elderly, considering their increased risk for suicide."

  Yrsavage, Postgraduate Medicine, 1992.

TREATMENT (Con't)

- Other Antidepressants
  - Bupropion (Wellbutrin)
  - Venlafaxine (Effexor)
  - Nefazadone (Serzone)
  - Trazadone (Desyrel)
  - Remeron

TREATMENT (con't)

- Response depends on:
  - Adequate length of treatment (6 - 12 weeks)
  - Dose and Blood Levels
  - Compliance - 70% of patients fail to take 25% to 50% of their medication. Non-compliance predicts poor outcome.

ELECTRO CONVULSIVE THERAPY (ECT)

- ECT has an Important Role in Treatment of Depression in the Elderly
- A National Institute of Mental Health (NIMH) study shows patients over 61 constitute the largest age group who receive ECT.
- Efficacy for short-term response is strong. Relapses are frequent.
- Maintenance ECT and maintenance antidepressants post-ECT helps.

PSYCHOSOCIAL TREATMENTS

- Psychosocial treatments have very few studies on efficacy
  - Cognitive therapy
  - Behavior therapy
  - Interpersonal therapy
  - Short-term psychodynamic therapy
  - Social support and treatment of family caregivers

PSYCHOSOCIAL TREATMENTS (con't)

- Special approaches to treatment for the elderly with physical illnesses and disabilities
  - Visual & hearing impairment
  - Cognitive impairment
- Senior centers with therapeutic recreational activities, nutritional programs and volunteer services, etc.

TREATMENT OF SECONDARY DEPRESSION

- Concurrent medical illnesses
  - To be treated as virgorously as primary depression
- Self-help groups for approximately 800, 000 persons widowed each year
- If untreated secondary depression can lead to Major Depression **and Suicide**

SUMMARY AND CONCLUSIONS

- Depression is common in the elderly, but often underdiagnosed and undertreated
- Accurate diagnosis is important to determine cause of depression
- Depression in elderly should be vigorously treated
- Consider full-dose maintenance therapy

SUMMARY AND CONCLUSIONS

- Selective serotonin reuptake inhibitors are effective and preferred in elderly
- Desipramine and nortriptyline should be prescribed cautiously
- Trazodone, bupropion, MAOIs, ECT may be useful alternatives